Towards the Healthy Women Counselling Guide

Ideas from the Gender & Health Research Group, WHO

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INTERNATIONAL SERVICES ASSOCIATION
5/1, BENSON CROSS ROAD,
BENSON TOWN, BANGALORE-560 046.
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Towards the Healthy Women Counselling Guide

Ideas from the Gender & Health Research Group, World Health Organization.

Based on research by:
Halima Abdullah Mwenesi, Esther I. Njiro, Margaret Gatei and Theresa Gatabaki (Kenya)
Isatta Wurie and Muriel Harris (Sierra Leone)
Mere Nakateregga Kisekka, Mairo Alti-Mu'Azu and Suleiman Salau (Nigeria)

Writers:
Carol Vlassoff, Ralph Hardy and Eva Rathgeber

Editors:
Victoria Francis and Giselle Weiss

Illustrator:
Victoria Francis

Towards the Healthy Women Counselling Guide

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Foreword

This booklet documents a process: it lays out steps towards developing health materials for women. The booklet is intended for health personnel, policy makers, non-governmental organizations (NGOs) and others interested in promoting the health of women, particularly the most hard-to-reach women in the most isolated circumstances. It does not contain final solutions or foolproof methods for reaching this goal. Rather, it contains ideas that have emerged from the process of attempting to develop appropriate materials within the World Health Organization (WHO), and observations and suggestions from rural women themselves in three African countries.

To address women's health concerns in a comprehensive way, the Gender and Health Research Group, an informal working group of WHO, in conjunction with researchers and community development workers, is planning to develop and test a Healthy Women Counselling Guide for women, both literate and illiterate, in developing countries. It is intended for all women, but especially for those who live in the poorest and most remote rural communities and secluded social situations.

This initiative stems from a concern that women's health in a holistic sense (that is, the total health of the woman, not restricted to her role as mother, or to specific periods of her life) has been neglected. Convinced that easy-to-follow health information could be provided to women, the Gender and Health Research Group developed simple messages it considered important for improving and sustaining good health practices among women.

Specific health messages were suggested by the following WHO Programmes: Special Programme for Research and Training in Tropical Diseases (TDR); Division of Control of Tropical Diseases (CTD); Special Programme of Research, Development and Research Training in Human Reproduction (HRP); Division of Family Health (FHE), Global Tuberculosis Programme (GTB); Global Programme on

AIDS (GPA); Division of Diarrhoeal and Acute Respiratory Disease Control (CDR); Programme on Substance Abuse (PSA), and Oral Health (ORH). Suggestions and support were also provided by the Adviser on Health and Development Policies (DGH), Office of Global and Integrated Environmental Health (EHG), Division of Operational Support in Environmental Health (EOS), Non-communicable Diseases (NCD), Division of Epidemiological Surveillance and Health Situation and Trend Assessment (HST), and the Division of Health Promotion, Education and Communication (HPR).

In late 1993, a meeting was held in Geneva with representatives of women's groups, health specialists, communication experts and researchers to obtain their suggestions for the Healthy Women Counselling Guide, including the form it should take and how to make it available.

The participants agreed that, while such a guide was of highest priority, preliminary research of a participatory nature was required to find out what women themselves needed, on the one hand, and the constraints facing health workers in their work with women, on the other. The participants argued that many health guides had been developed with a top-down approach, where materials were designed and prepared in settings far removed from countries where many diseases, such as malaria and schistosomiasis, for example, are endemic. Though these guides are often field-tested in developing country settings, this testing often results in superficial changes only, as the materials have been developed by programme officers, and not in collaboration with the users. For this reason it was recommended that women and health workers at the local level in developing countries be involved in the process right from the start, so that the emerging materials and messages would be meaningful to women and represent, in fact, their own product.

A 'Call for Letters of Intent' for rapid research following on from the above suggestions was quickly produced by the Gender and Health Research Group, and three proposals were selected: from Kenya, Sierra Leone and Nigeria. The research focused on women's health needs and priorities, their health-seeking behaviour, where, how,

and from whom they would like to receive health information and a variety of other questions related to the aims of the Healthy Women Counselling Guide. The studies were funded by TDR. The results of this research are presented in this document.*

Research is continuing on the Guide itself, based on the suggestions contained in this booklet. Many ideas regarding the form and entry points for the Guide continue to be explored intensely. Several products have emerged from this process, including a manual for health workers (see box). It is hoped that the Healthy Women Counselling Guide will remain a dynamic process, continually evolving to bring about and sustain the empowerment of women through access to better health and the tools with which to obtain it.

Carol Vlassoff

*Partial financial support for this project was received from Canada's International Development Research Centre through its office in Nairobi, Kenya.

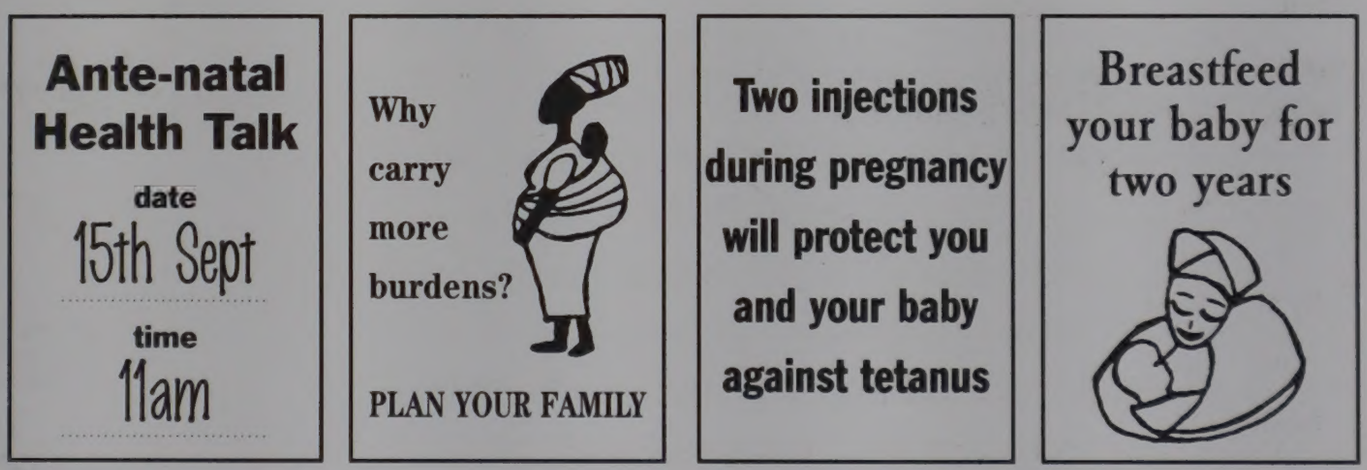
A manual entitled Health Workers for Change has been developed as a training tool for health workers, to better equip them to deal with their daily challenges and frustrations, and to help them to relate in a more positive way to their female clients. The methods used in the manual are based on an approach developed in South Africa and tested, with TDR funding, in four other African countries: Mozambique, Senegal, Uganda and Zambia. The approach was highly successful in all countries, despite cultural differences, and it was appreciated by health workers at all levels. The methods presented in the health workers' manual incorporate the suggestions, experiences and cultural differences found in the various sites. Health Workers for Change complements the Towards the Healthy Women Counselling Guide in that it approaches women's health in a comprehensive way. The information given to women in the Healthy Women Counselling Guide will also be strengthened by more positive feedback and interaction between women and health workers.

Introduction

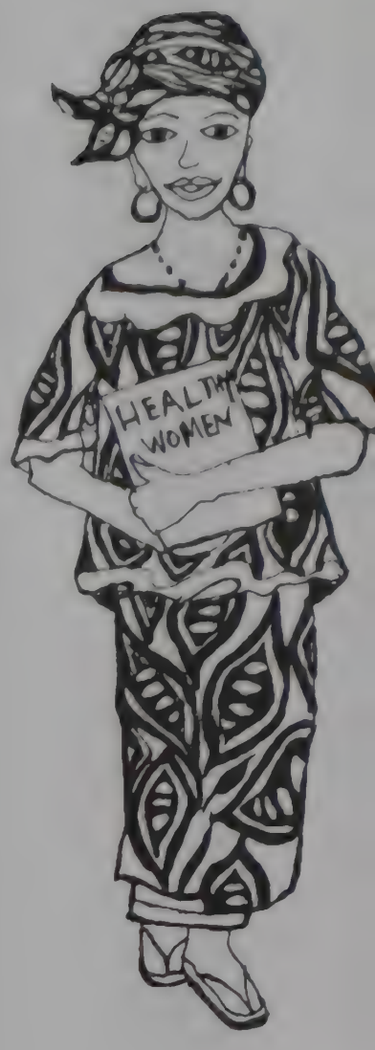
Women's health has never been a high priority in international aid programmes. Attention to women's health in non-industrialized countries has traditionally concentrated on other concerns, such as family planning and child survival.

There is little information on women's health problems in developing countries. Except for the special needs arising from pregnancy and childbirth, medical science has largely assumed that infection and disease affect men and women in the same way. Women everywhere have tended to accept this lack of attention to their needs because of their lower status, and their reluctance to question the predominantly male medical establishment.

Women's health is often equated with family planning and child survival.



In the areas of employment, education and legislation the need for gender-specific information – that is, information about the differences in social role between men and women – is widely acknowledged; yet health care has largely ignored issues of gender. Although women in industrialized countries have begun to question this lack of information as well as the quality of health care they receive, in developing countries women's low status prevents them from recognizing and voicing such concerns.



The idea of the Healthy Women Counselling Guide was conceived by several programmes of the World Health Organization as a communication tool for rural women. The Guide aims to provide health information so that both literate and illiterate women can readily understand it. The Guide will focus first on rural Africa, but it may be adapted later for women in other developing areas.

To find out what women themselves need, the kind of health information they prefer and where and how they obtain this information, three participatory research projects were undertaken in Kenya, Nigeria and Sierra Leone. The results of this research provide the basis for this document, and for the preparation of the Guide itself. It should be emphasized that these studies were conducted in a small number of communities and the data gathered is entirely qualitative. No quantitative or numerical results are given. Hence, we cannot generalize their findings to all members of the communities studied, nor to the countries more generally.

Nonetheless, the results are strikingly similar across the different geographical and cultural settings, especially with respect to gender relations and women's health. WHO is therefore confident that this research has laid a firm foundation for the further development of the Healthy Women Counselling Guide.

Part 1

REACHING WOMEN WITH HEALTH INFORMATION – THE CHALLENGE

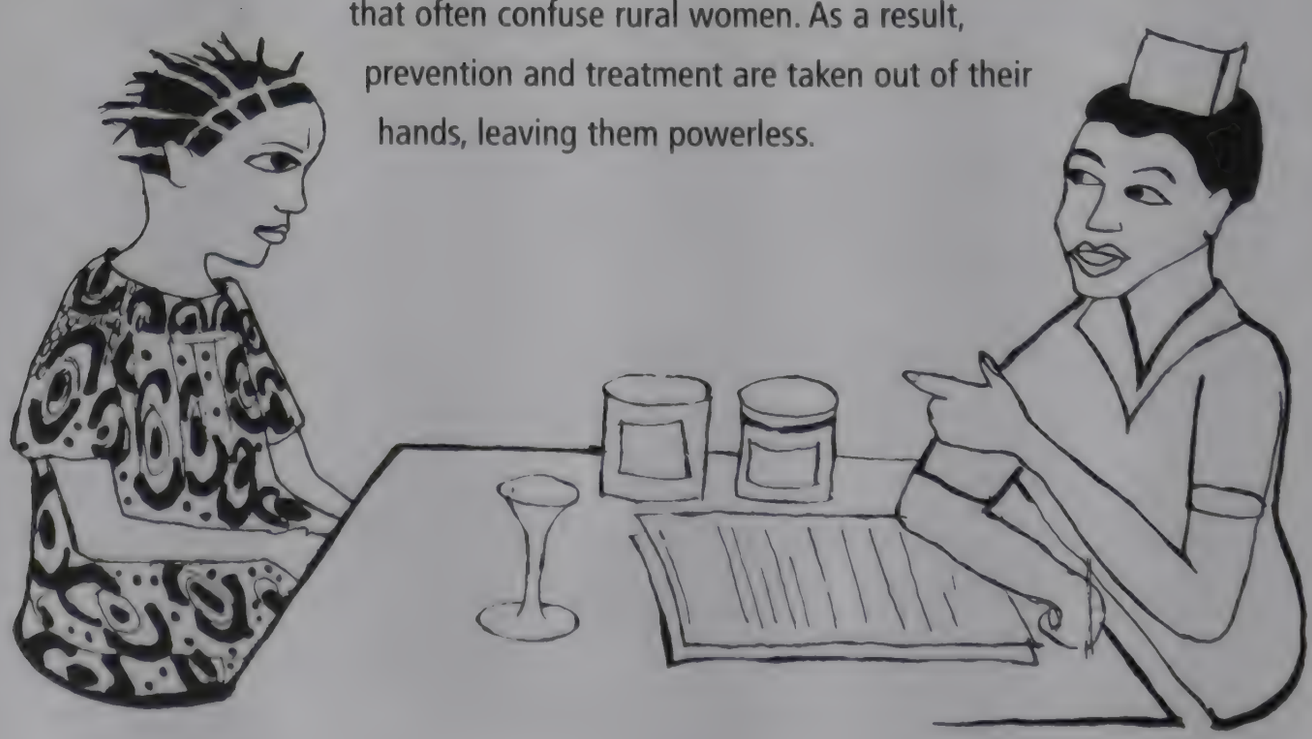
Why is it important to reach women with health information?

Women lack information about their health

Women have a wealth of local knowledge about how to prevent and cure disease, including the use of traditional plants and herbs. But they have little information about things that put their health at risk, such as the complex transmission processes of many diseases or modern methods of prevention and treatment.

Modern medicine pays little attention to women's local knowledge and explanations. At the same time, health professionals sometimes fail to give satisfactory alternative explanations. Doctors and health workers tend to release knowledge when they consider it to be appropriate, with little consideration of what women might need to understand about their treatment or prescriptions. Moreover, health education is structured around biomedical explanations of disease that often confuse rural women. As a result, prevention and treatment are taken out of their hands, leaving them powerless.

Biomedical explanations of disease often confuse rural women.



Development projects usually focus on men, expecting that they will pass on the information to women in their households and families. But this is often not the case. Even where men do convey information to their wives or other female family members, they may only pass on some of the information. Men may talk only with certain women, such as mothers or senior wives, who might not be

Information is often given only to men, expecting that they will pass the information on to women in their households.

the ones most likely to use or pass on the information. Just as status within the family affects women's access to information about health, their status within the community affects their motivation to participate in community health activities. Many development projects aimed at women have been unsuccessful because they do not recognise how difficult it is for women to apply

what they have learned in their own context. Many projects designed to give women technological training in agriculture have failed and, in some cases, have even been sabotaged by others. This is because decision makers sometimes judge that women are unable to learn. Sometimes, too, those in power want to preserve their own interests. In this way the status gap between the sexes is maintained.

Women report less frequently than others to health services

In developing countries long queues of women wait at clinics, but they are often seeking care for their children rather than for themselves. Women sometimes use these visits to ask about their own health problems, but maternal and child health or 'safe motherhood' services focus primarily on reproductive health. Health workers at these services may ignore women with obvious diseases such as elephantiasis or leprosy because they are unsightly. Or they may lack the training, drugs or facilities to treat them.

In most developing countries men use health services for their own health concerns more often than women do. Women are more likely to treat themselves or to seek traditional healing and advice. So even when they are affected by such diseases as malaria and schistosomiasis, women may only use the health services as a last resort. Also, many diseases, especially those that are believed to be transmitted sexually, are considered shameful, and women hesitate to ask health workers about them.

In some parts of the world, boys are more readily taken to modern health facilities than girls. This is because it is often male members who make the decisions about spending money, and they give preference to male children for treatment. Women also tend to treat boys differently from girls.

Recognising these problems and finding ways to reach these 'missing women' are fundamental to developing the Healthy Women Counselling Guide.

Women are the main health providers in the family

Women are usually the first to be consulted when family members are ill. They make decisions about what care is required, from home remedies to pharmacy or hospital visits. Their role as caregivers is widely recognised, but it is not fully understood or valued. It is often taken for granted as merely 'traditional'.

At a time when many national health care systems face severely limited resources, women's potential for positive health action both for themselves and for their families is significant. Their knowledge and experience in providing health care is a resource on which modern medical science can draw. Efforts should therefore be made to enhance the credibility and power of women in an area where they already have considerable skill.

Whom do we want to reach?

Women who are hard to reach with health information

We want to reach women who, for a number of reasons, receive little information about their own health:

- *rural women in developing countries*
- *poor urban women*
- *women who are heads of households in both rural and urban areas*

Many of these women have not benefited from formal education and cannot understand the writing or illustrations on health education posters or directions on medications. Many do not receive information from the mass media. Women in seclusion in Islamic countries also need more complete and accurate health information, presented and delivered in culturally appropriate ways.

RURAL WOMEN

POOR URBAN WOMEN

WOMEN IN SECLUSION

Women are eager for information

Women are eager for health information that is relevant to their needs and experience. They are often weak, anaemic and suffering from troublesome yet unattended health problems such as backache, parasitic diseases and reproductive tract infections. They are also eager for appropriate health information that can help them take care of their families.

Development agencies concerned with income generation or other programmes for women have noted that women frequently complain about their health problems, and ask that these be attended to first. Health information is a felt need among women. They are likely to listen to and use it if it answers their worries about their own health, and that of family members, in ways that are acceptable to them and build on their own understanding of health.

The challenge is to provide information that poor, often illiterate, women can easily understand. It should be meaningful, useful and available in places that they can easily reach and be provided by people they trust.

Finding the right place

The most obvious way to provide health information to women is through existing health services. This would mean giving the information to health facilities and improving their capacity to deliver it.

This approach, however, has certain drawbacks. It may be difficult to orient local health services to counsel women on health issues beyond those for which they are normally responsible. Furthermore, many women may hesitate to use the services for non-reproductive concerns, since they have come to think of health services as dealing with family planning, pregnancy and child care. Also, women who fall outside traditional MCH services, such as those who are unmarried or no longer child bearing, may be missed. It may therefore be necessary

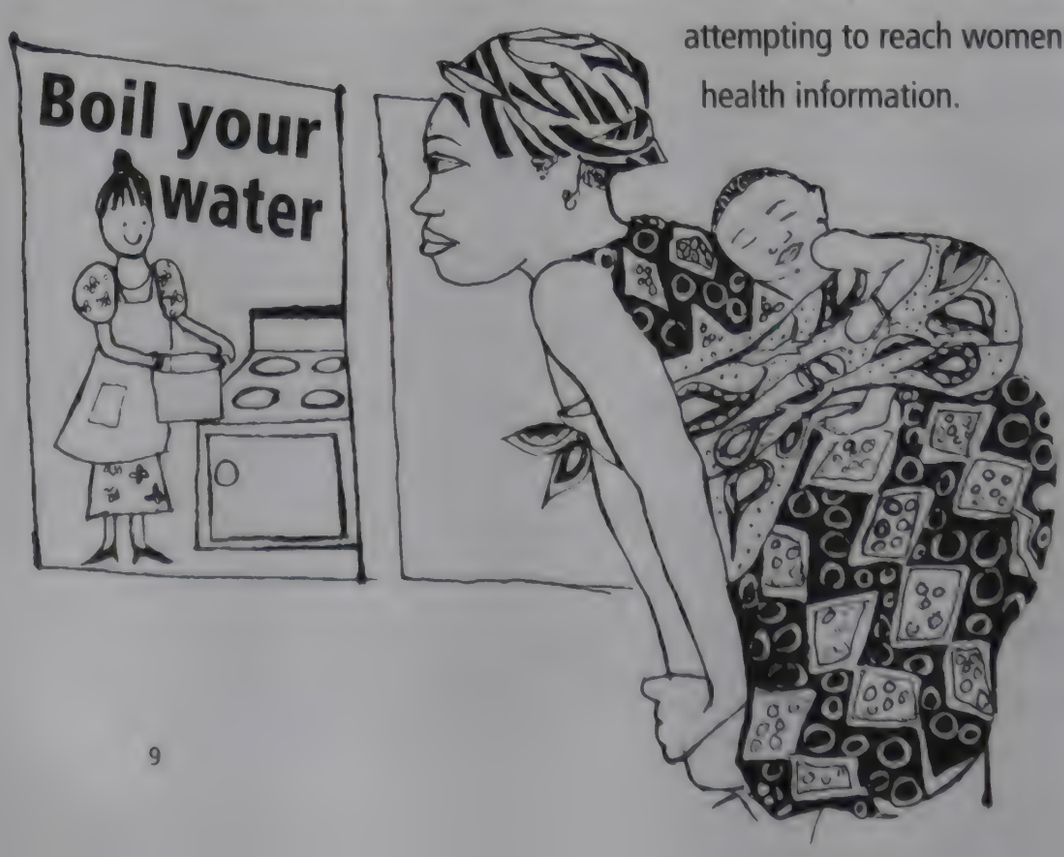
to find alternative places to provide health information and counselling to women. We need to think creatively about places that women can easily reach, where they feel comfortable and where they are able to express themselves freely. Such places may not usually be associated with health issues.

Finding the right medium

Information should be presented in ways that rural woman can relate to and understand. Much health education in the past has failed because the medium of communication is inappropriate or the messages themselves are not based in the local culture. In rural Egypt, for example, women laughed at a schistosomiasis prevention programme on television because it showed shoe-clad women walking to a stream, whereas local women did not wear shoes. Women thus did not identify with those portrayed in the film and did not feel inclined to take the information seriously, as something that is relevant to them and their problems.

How can modern health information be translated into material that is meaningful and useful to women? What kinds of information do women pay attention to? Can women themselves participate in designing health messages? Are women more likely to act on health information that they have helped to create? And how easy is it to adapt health materials developed in one geographical setting to other areas and sociocultural contexts? All these are questions that arise in attempting to reach women with health information.

Health education often advocates things that rural women cannot do.



Finding the right time

No matter how much women may want information about their health, there are certain times of the day, week, month or season when other needs are of a higher priority. One reason why many women do not attend health clinics regularly is that these facilities have strictly regulated working hours that conflict with women's other responsibilities. Also, women feel that time spent waiting in queues could more profitably be spent doing domestic or paid work.

We need to be aware of women's heavy workload and the many competing demands on their time. Health information should be available when women have time to use it. This may be done by changing consultation hours in clinics or by designing and distributing materials in such a way that women can consult them whenever they have the need or the time, and by working with groups that are based in the community and can arrange for discussions at a time when women are more free.

Women should be able to consult materials when they have the need or the time.

Commitment to reaching women

A change in philosophy is needed

To reach rural women, a change in philosophy is needed. Traditionally, strategies to communicate health messages have been driven by the goals of policy makers and senior health professionals. A change in perspective is required, starting from where rural women are in their thinking and experience. The possibilities open to them for change must also be taken into account.

Materials design should start from what women want to know.

Those who seek to communicate meaningfully with rural women need to recognize that:

- *Local perceptions of health and illness are valid, and should be accepted and incorporated into information design.*
- *Women already perform a health care-giving role that they and their families value. Information should enhance this role rather than undermine it.*
- *Women's actions are determined by the contexts in which they live. It is important to recognize how gender relations affect their health, and their ability to implement changes in their lives and those of their families.*

Recognizing the value of local perceptions

Rural women's understanding of health and disease is often dismissed as irrational, and words like 'ignorant' and 'superstitious' are frequently used to describe their behaviour. Research, however, has shown that local understandings of health and illness can be complex and detailed. Given the opportunity, rural women are able to explain their interpretations and observations in ways that are inherently rational. Their reasoning is inductive – based on lived experiences and built up over time, just as modern medicine is.

Local perceptions of health and illness should be understood and appreciated. Their basis and the validity they have for local people must be recognized and taken into account in the design of new health information. In many cases people's behaviour corresponds closely to modern medical ideas. Only certain aspects that are inappropriate or harmful may need to be pointed out. Health information can be designed to incorporate traditional and modern biomedical practices so that it is meaningful within women's lives and within their range of possible actions.

Recognizing the value of women's traditional health care-giving role

For women in developing countries, as elsewhere, preserving personal and family life and caring for ill family members is a primary responsibility. This role is valued not only by women themselves but also by others in the family. Modern health facilities encourage reliance on their services and discourage traditional ways of dealing with problems. Thus, an area in which women once fulfilled a valuable role that gave them considerable prestige and recognition is now undermined. The guiding philosophy should be one that works towards the empowerment of women, strengthening their traditional care-giving role in the family and community.

Recognizing gender issues and the contexts of women's lives

Providing health care is only one of a long list of women's responsibilities. Other concerns, such as earning income, securing daily firewood and water, and child care may be even more immediate and pressing.

The studies from Kenya, Sierra Leone and Nigeria provide useful insights into women's lives from the perspective of gender relations, and the constraints within which women cope with health and illness. A change of philosophy is needed in order to recognize that women's ability to cope with their own and their families' health is determined by their position in society and the many pressures on them.

Part 2

Rapid research to aid understanding

In order to reach women with health information, we need to find answers to the following questions:

- *How do gender relations affect women's health?*
- *Why do women 'ignore' their health?*
- *What do women do when they are sick?*
- *What is a 'healthy woman'?*
- *Where do women obtain health information?*
- *What kinds of information do women listen to and why?*
- *How can women be empowered to improve their health?*

To find answers to these questions, a methodology was developed that provided a wealth of information in a short period of time. It consisted entirely of qualitative research methods, which rely on people's own written or spoken words and observations and which use techniques such as focus groups, in-depth interviews, key informant interviews and observation to obtain descriptive data. The sites chosen for the studies were typical rural areas: in Kenya, Tunyai and Chiakariga Locations of Tharaka Nithi District of Eastern Kenya; in Sierra Leone, 16 villages in Koya Rural District and Koya

Focus group discussions were held with community women.

Chiefdom, Port Loko District; and in Nigeria, three communities in Makarfi local government area of Kaduna State, representing three ethnic groups (Hausa, Maguzawa and Fulani). In all studies, members from the entire community were involved in the interviews, which focused on five categories of respondents:

(1) community women;
(2) men of different ages;
(3) opinion leaders;
(4) women's groups; and
(5) community health providers.

Towards the end of the research, women suggested ideas for health information, and participated in the design of specific health messages.

Local women prepared materials.

The research, conducted by multidisciplinary teams of social scientists, communicators and field assistants, involved up to four months of data collection. Data from the interviews and observations were continuously entered into portable computers during the fieldwork. In addition, local women prepared materials including posters, a story and a clinic talk.

The core protocol using these studies may be obtained from TDR/WHO. The protocol provides an outline of the methodology, including discussion guides, for the various methods and groups involved. It will not always be feasible to carry out as many of the activities as are recommended in the protocol. As a matter of policy, however, it is strongly advised that research at the community level precede interventions. At a minimum, information should be obtained from female opinion leaders and health providers, using focus groups and in-depth interviews. Information about men's attitudes can be sought from male opinion leaders.

Gender relations and women's health

Women's socialization

In Sierra Leone, Kenya and Nigeria a woman's status is conferred by the community in which she lives. Women are valued first for their role in reproduction. Marriage is nearly universal, and arranged by parents; early marriage, often before menstruation begins, is common. In the Islamic communities studied in Nigeria and Sierra Leone, polygamy is the norm, and in these arrangements, the status of individual women is variable, with senior wives ranking over their juniors.

The socialization of women as inferior is pervasive. In every study, female respondents said they would prefer to be men or that women should be subservient to men. In a Muslim community in Sierra Leone, women expressed the need to be 'owned', and the desire to 'have a man to belong to'. Adult literacy classes in Nigeria are Koranic and serve to reinforce the subordinate status of women. Furthermore, many men seem uneasy about the concept of 'educated' wives, fearing that 'women will learn how to argue with husbands'.

Gender discrimination

Gender discrimination begins early. In the Hausa community of Nigeria, the birth of a boy is cause for celebration and is announced by seven ululations; for a girl the number is three. Education levels for girls in all three countries were lower than those for boys. In Sierra Leone, for example, national literacy levels are less than 25 per cent for women, compared with 46 per cent for men. Adult literacy classes are offered in some communities, but for good reasons women do not always take advantage of them: they can be expensive, or they are held in the evening when women require permission to leave home.

Girls don't often get the chance for education.

Some women enjoy higher status

In the study areas, two groups of women enjoyed higher status: sex workers and post-menopausal women. Older women, by virtue of the number of children they have borne and the amount of wisdom they have acquired, are typically respected throughout most communities. Within Islamic societies the constraints of purdah do not apply to older women, and they may travel without permission from men.

Sex workers, particularly in the Nigerian study, enjoy a degree of autonomy much greater than that of married women in their own community. They may also appear more sophisticated because of their exposure to customers of differing sociocultural backgrounds. It is not uncommon for them to participate freely in drama groups and adult education classes, as well as NGO activities. Men were quoted as saying they could talk more freely to sex workers than to their own wives; however, it should be noted that the status of sex workers was often ambiguous. For instance, they felt powerless to demand that their male customers wear condoms.

Women's low economic status reinforces dependency

Women are further disadvantaged economically. In most cases they cannot own land or the means of production. Thus they are financially dependent on their fathers, husbands and sons to provide for them throughout their lives. Women in Nigeria reported that, in times of scarcity, 'children are fed first, then the old people, since they have already become as young children, and then the father since he provides the food'.

Young male discussants in Nigeria observed that 'women are useless' because they cannot even pay their children's school fees. This economic and legal dependency on men was evident in all study sites. Recently, cooperatives have been formed to relieve some of the financial burdens women face. Still, these programmes are distrusted by some men 'because there are things which they do which lead women to demand equality'.

Women are valued for their capacity to work long hours, whether in income-generating projects in the home, tending to domestic duties or farming. In Kenya, women often manage the household while the men migrate in search of employment.

Religious interpretations may endorse women's inferior status

Overzealous interpretations of religious dogma can sometimes reinforce the inferior status of women. For example, in some areas, religion has undermined government family planning programmes, thus perpetuating the poverty of women through frequent births, which drain their energy and worsen their health. Some religions are gender hierarchical, with women serving on the lowest rung.

In the study communities, religious leaders depict themselves as credible sources of health information. For example, they mention the expanded programme of immunization (EPI), which became acceptable after religious leaders intervened to counteract rumours that these programmes were a form of birth control. But family planning and the use of condoms are issues about which religious leaders are dogmatic. Some religious leaders speak disparagingly of 'modern hospitals', dismissing them as places where male doctors instruct women to 'strip naked so they can examine them'. Overzealous interpretations of religious teachings help to legitimize women's lower status in these communities.

The perspective of men

In Sierra Leone, Kenya and Nigeria, men play a paramount role in determining the health of women. As men are generally the decision makers in these communities, they determine when and where women seek health care. In most cases it is their money that pays for the treatment. Thus, intervention strategies to improve women's health must work through men, or at least with their cooperation.

Men are typically better educated than their female counterparts, and have greater access to information, including health information. Because of these educational disparities, men often hold patronizing attitudes towards their wives or other women. Male respondents use terms such as 'foolish' and 'neglectful' as a means of disparaging women's health-seeking behaviour. Furthermore, through purdah and other cultural constraints, men control women's access to health information, thus perpetuating gender stereotypes.

Despite men's higher educational levels, they are often poorly informed about women's health issues. Also, their beliefs may create contradictory situations for women. For example, among the Hausa men in Nigeria, early marriage for girls was simultaneously labelled as both 'acceptable' and 'harmful' by community men, illustrating an untenable position for young girls in that community.

Men and older women also help to enforce harmful cultural taboos, such as dietary restrictions for pregnant women. They have the power to enforce their decisions through social, economic, legal and religious institutions, to which women have almost no recourse.

The woman's role as care-giver comes before her own needs

Women acknowledge that they are indispensable for performing virtually all household tasks, yet they are dispensable because they can be replaced by another woman. The following case study from Kenya emphasizes this paradox:

'The woman would continue to work even when she was sick because the husband would not assist in whatever happened. Then one day she went to look after the livestock which were feeding in a nearby field and she fell from exhaustion and sickness. Her husband was not aware that his wife had fallen in the field, and he continued to call her so as to reprimand her for letting the livestock wander on its own. Little did he know that she was dead, until a passer-by saw her body lying in the field....The man was not ashamed of himself at all, and he soon got married to another woman'.

Children, who are generally weaker and more prone to illnesses, are the first to benefit from health services when resources are limited. When a husband is sick, the wife must attend to his needs as well. In Sierra Leone a married man described a woman's responsibility towards his health this way: 'The woman should take care of me, giving me treatment

by taking me to the hospital or taking me to the traditional healer to heal me if the illness doesn't pertain to hospital. If I am unable to bathe, she fetches water and bathes me. She should take care of the family as well'.

The scarcity of economic resources available to women was noted in every study. Because most clinics provide fee-based services, with the general exception of immunizations, women are dependent on men to give them money for treatment and, often, for permission to leave home to receive it. Sometimes these negotiations can last a week or more, during which a woman's health might decline even further, or a simple infection might spread. In Sierra Leone one respondent said that without permission from the husband to pay for a hospital delivery, he might 'refuse to pay for hospital treatment', or worse, not accept that the child is his.

Why do women 'ignore' their health?

Women in developing countries place themselves last in their family when seeking health care. There are a number of reasons for this.

Often, health care services are far away and require long treks on foot to reach them. Because household chores are culturally ascribed, many women believe that their homes and families would collapse without their attention. They learn to expect little help from their husbands in this regard. Health treatment is frequently a last resort, particularly for women who lack the necessary cash for medical services or transportation to the health facility. In some cultures, women are not allowed to be seen by a male health worker. Health personnel, both male and female, may also treat women as inferior, and blame them for coming late for treatment. Thus women tend to seek alternative treatment such as traditional healers or self-medication until they are very ill and incapable of working. Men go more readily to modern health services.

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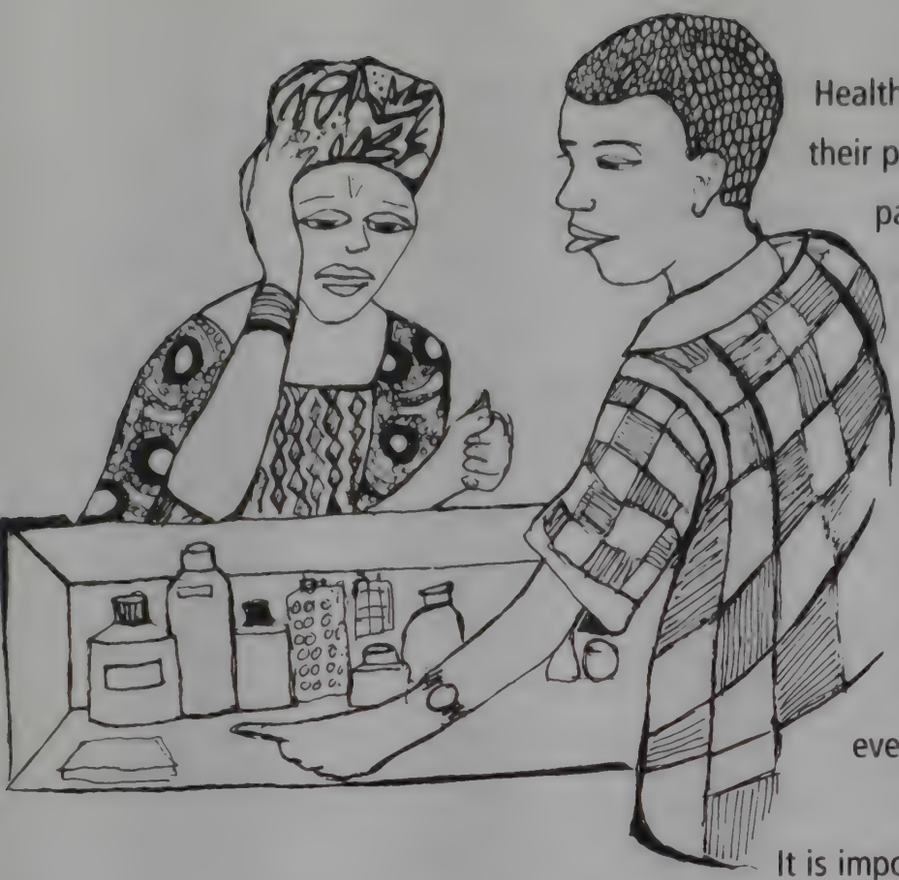
Cultural expectations often demand stoic acceptance of endemic diseases such as malaria. As one respondent from Kenya observed: 'A woman never gets sick – even when she is ill to the point of death, she is expected to perform her duties'.

Because women perceive themselves as having different rights from men, it is hardly surprising that they do not feel they have the right to good health. This perception, as evidenced in the three studies, leads women not to 'ignore' their own health, but rather to endure their illnesses until they are unbearable.

Women do not feel they have the right to good health.

What do women do when they are sick?

In Kenya, Nigeria and Sierra Leone health-seeking behaviour for women is difficult to predict. In most cases women first use home remedies and traditional medicines for their illnesses. If these fail and symptoms persist, they will seek low-cost treatment in the form of painkillers, topical creams and other over-the-counter drugs. Women consider this type of treatment to be most effective for malaria, colds and coughs, and head- and stomach-aches. Sometimes, if drugs are left over from a previous illness, they will be used for a later illness, regardless of expiration dates or contraindications.



Many patients prefer to buy low cost painkillers from drug peddlers.

Health care providers admit that many of their patients prefer to buy low-cost painkillers from drug peddlers before resorting to more expensive treatment. If the painkillers are effective, a woman may continue to work in order to give the appearance of good health, or to earn enough money to pay for a hospital visit. This type of coping strategy was mentioned in every study.

It is important to note that health-seeking behaviour is perceived as dynamic: patients go back and forth between traditional and modern systems. People weigh up many factors before choosing a health care system, and this choice is not always rigid. These factors include the perceived cause of the illness, its severity, access to health care, cost of treatment and cultural constraints. Educational levels and literacy alone are not accurate predictors of health-seeking behaviour.

Health services – a last resort

Treatment costs can be prohibitive

In every study treatment at hospitals and health centres was considered a last resort. In Nigeria, some traditional healers and birth attendants openly criticized formal health services as 'dirty' and 'exploitive' because of the high costs involved. Traditional healers and birth attendants charge less for their services than do hospitals, one can pay in installments or in kind.

Health facilities are often insensitive to women

Another important constraint women encounter, particularly in Islamic communities, is the lack of female physicians. For a woman in purdah to be examined by a man brings shame and dishonour to herself and her family. In situations where women must have

permission from their husbands to seek modern treatment, one can see why men in Islamic communities would be reluctant to grant it.

Sexual harassment by male health workers, sometimes in the form of offering treatment and drugs in exchange for sexual favours, is a common and serious complaint noted in every study.

In all studies health providers exhibited frustration towards women clients because they come late for treatment and often do not heed their advice. In many cases the workers are not sensitive to the cultural constraints that women face. Women, on the other hand, often see health providers as rude and patronizing. The Kenya study reported that women object to being told what to do by health care workers who have no knowledge of their personal situations:

'They are tired of being told to boil drinking water, wash hands after defecating and give their children a balanced diet. This is an area where water is scarce. To expect people to boil water and carry it with them during their long journeys, either to the rivers or

Hospitals are often frightening to rural women.

the main roads, is not realistic. Further, because of lack of latrines, people defecate in the abundant bush where water is not available. The message of a balanced diet has apparently been abandoned because...the issue is to get enough of whatever food is available'.

Health services are often inadequate

In all study areas formal health services were inadequate, and the shortage of doctors acute. In many cases a health clinic is 50 kilometres from villages. In the rainy seasons roads are frequently impassable on foot, and public transportation is rare and expensive. Limited drug availability, water and electrical shortages, the lack of diagnostic equipment, poorly trained and sometimes hostile personnel, and the great distances most patients must travel constitute a health care system in crisis.

In Nigeria frequent labour strikes have closed down many health facilities for long periods. Patients must then resort to chemists and even less qualified drug peddlers for diagnostic and medical treatment.

Delay in seeking help makes problems worse

Because most women wait to seek formal health care until their symptoms are severe, health workers must deal with patients in advanced stages of illness. In Sierra Leone one woman related a typical case: 'Last year I was suffering from an eye infection, but I could not go to the hospital at the initial stage because I was using herbs. But the infection got serious and I had to go to the hospital and the eyes were cured'.

This delayed response drives up the cost of treatment, which increases the stress on the patient. One Kenyan health provider said that women 'complicate simple conditions with irrational over-the-counter drug use'.

Poor and illiterate women are at a disadvantage

Illiteracy is another burden for women to overcome in seeking health care. Because women are often unable to read prescriptions

or even register themselves, they sometimes find a modern hospital's procedures daunting or confusing. Health workers criticize patients because they cannot follow written instructions. They also say that women will not reveal all of their symptoms, which makes treatment difficult.

Poorer rural women often reported feeling at a disadvantage when seeking health care. They felt that patients who were better dressed were more likely to get polite, respectful treatment, as well as better access to scarce drugs.

Women are afraid to report stigmatizing diseases

A wide range of stigmatizing illnesses, such as sexually transmitted diseases (STDs), vaginal infections, tuberculosis (TB) and asthma, were found in the study areas. Most of these are believed to have resulted from breaking cultural taboos. For instance, among the Athakara in Kenya, the use of pit latrines is culturally unacceptable. Hence, two respiratory ailments, asthma and tuberculosis, which are believed to result from inhaling the fumes of latrines, bring shame and stigma on the sufferer. Attempts to promote the use of pit latrines have largely failed in this area because they challenge strong cultural taboos.

Sexually transmitted diseases (STDs) are prevalent in the communities studied. In Sierra Leone, gonorrhoea was considered a 'man's disease' and one that 'any mature person is bound to have'. Among the Fulani men in Nigeria, STDs are associated with their manhood initiation rites, which are usually followed by patronage of sex workers. In this way the idea that 'women are the cause of STDs' is perpetuated.

In all countries studied, STDs are commonly believed to result from the immoral behaviour of

women. Little attention is given to the obvious transmission route of husbands visiting sex workers. According to traditional healers in Nigeria, 'men visit prostitutes, get the disease and pass it on to their wives. Their wives do not tell anybody because no woman wants to reveal the fact that her husband is having affairs'.

In Kenya, women seeking treatment for STDs were concerned that health providers might reveal 'their shame' to other people in the community. Health providers say that STD sufferers rarely bring their partners along for treatment, thus allowing the disease to remain untreated.

Information regarding HIV and AIDS was systematically lacking in all communities. Most respondents insisted they knew no one who had died from the disease, though sex workers in Nigeria were aware of its transmission routes and deplored their inability to persuade their patrons to wear condoms.

The Kenya study reported that stigmatizing diseases are generally ignored until they become severe. Women suffering from these illnesses may go to a traditional healer first, 'because they are easier to talk to', before seeking formal treatment. In all countries, stigmatizing illnesses require a period of psychological preparedness before the sufferer will resort to the sometimes embarrassing treatment provided at health facilities.

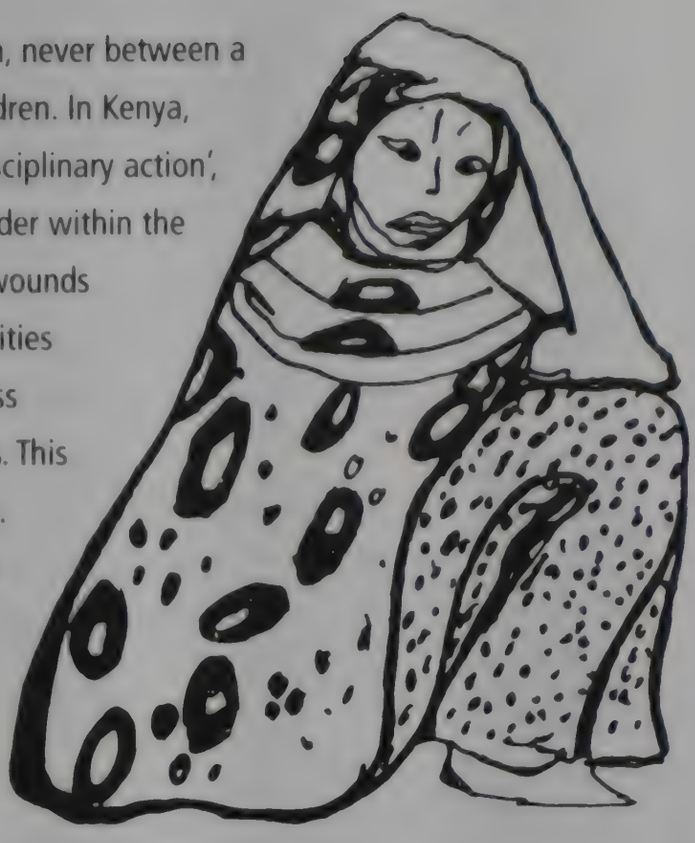
Other 'hidden diseases'

such as urinary tract infections, vesica vaginal fistulae (VVF) and vaginal itches are associated with promiscuity, and are stigmatized as well. Kenyan health workers, both modern and traditional, report that women never present directly with problems relating to sex, sexuality and sex organs, for fear of revealing STDs. Furthermore, matters related to childbirth are sometimes hidden because women are unwilling to disclose problems associated with giving birth at home.

Domestic violence

is another stigmatizing condition. Few women will report injuries incurred at home. Within the communities studied, violence is

defined as something that occurs between men, never between a man and his wife, or between parents and children. In Kenya, domestic violence is redefined as 'necessary disciplinary action', and is an acceptable method of maintaining order within the household. According to Kenyan respondents, wounds related to violence are not taken to health facilities because women fear they will be forced to press criminal assault charges against their husbands. This would not be acceptable within the community. All three studies showed a correlation between alcohol and violence within the home.



Sickle cell anaemia (SCA)
is a debilitating disease with costs similar to those associated with more obvious disabilities. The cause of SCA was poorly understood among the respondents. Because the disease is known to be heritable, most respondents associated it with evil spirits or considered it a punishment for the sins of parents or ancestors. Women who have SCA are frequently divorced by their husbands, who marry other wives because of the expense of treating the disease. One man said his wife's 'bad blood' was responsible for the death of his children from SCA.

Leprosy and skin diseases
are feared because they are often contagious and are associated with poor hygienic practices. In some areas these illnesses are viewed as a curse or as punishment from God. In these cases, the entire family might be blamed or labelled as 'wicked', thus bringing them shame. In Sierra Leone, women equated 'craw-craw'-(a skin infection) with STDs and other stigmatizing diseases. Again, unless treatment is available, women who suffer from these illnesses are often shunned or abandoned.

Epilepsy and other neurological and mental illnesses
are often believed to have supernatural origins. People seldom report these illnesses at modern health facilities; instead, they treat them by traditional methods.

Female circumcision is still widely practised

Despite official attempts to outlaw it, female circumcision is still practised throughout the study areas in Islamic and Christian communities. Because it is illegal, female circumcision is a 'hidden condition', but one that engenders high status among women in these patriarchal societies. The health problems that often result from female circumcision include urinary incontinence, bleeding, infections and complicated deliveries. Yet these are typically not reported at health clinics because women know that the practice of female circumcision is illegal. The Kenya report noted that many 'women suffer for years with these problems and never seek care for them'.

Among the Athakara in Kenya, girls are circumcised at about 15 years old. The event 'is a time of merrymaking and usually coincides with the harvest season when there is plenty to eat. The value of this ceremony is second only to childbirth in importance'. Most respondents, both men and women, felt circumcision was an important cultural practice 'which curbs immoral behaviour and gives guidance to the initiates on important matters of life'.

The potentially harmful side-effects of the operation are weighed against the increased status that it confers. As one woman observed: 'The signs of a circumcised girl can only be known by another circumcised woman. She walks carefully, sits well, has control over her temper, talks well, adheres to cultural values and is a faithful wife. The few incidents of unusual bleeding are too rare to warrant cause for concern'.

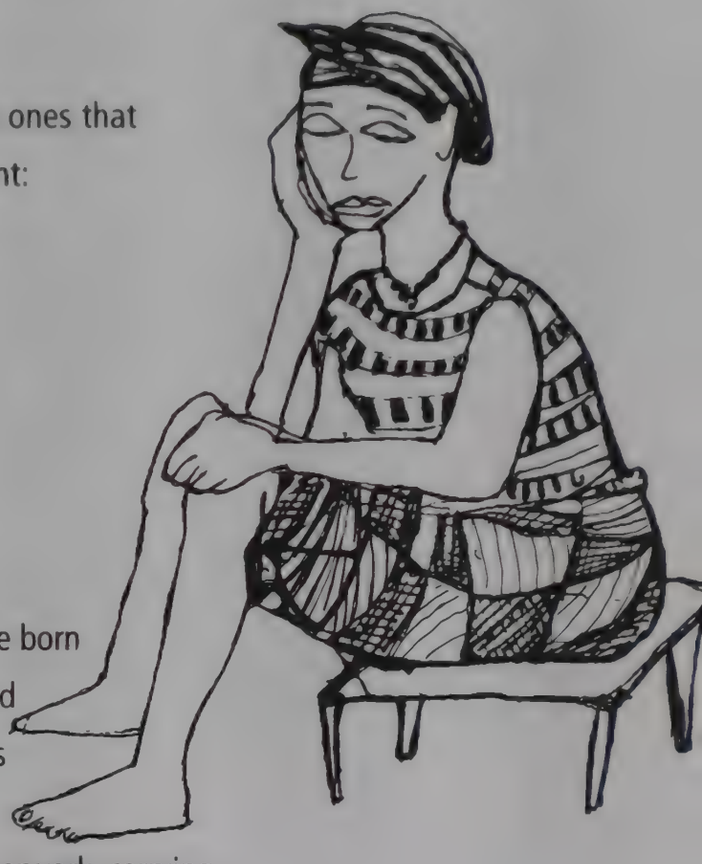
Older women with high status usually perform the operation, thus imbuing it with legitimacy among both sexes. Men who support the practice argue that their mothers were circumcised and they expect their wives to be circumcised as well.

Efforts to stop female circumcision have resulted in some modification of the procedure. The operation is banned in Kenya and, as a result, has been modified somewhat: now only the 'tip of the clitoris is nipped'. This type of circumcision is called 'gichomba', literally meaning 'civilized' or 'modern'.

Women learn to 'endure' certain problems

'Women must endure and be strong for as long as they are alive'.

In areas with high endemicity of diseases such as malaria and TB, women have learned to ignore and endure many health problems that they consider less severe. In a focus group discussion men in Sierra Leone agreed that a woman's health problems are not serious until she cannot 'stand, walk or talk'.



The following illnesses were noted in the studies as ones that women commonly endure without seeking treatment:

- *Premenstrual pain, headache, waist pain, colds and body pain (Nigeria)*
- *Headaches, common colds, cough and back pain (Kenya)*
- *Back pain, headaches, stomach-ache and side pain (Sierra Leone)*

One woman from Sierra Leone said that 'women were born with stomach-aches'. Another Kenyan woman reported that after a girl's first menstruation she would 'always have pain'. Every study noted the high prevalence of backaches. In many cases these were attributed to overwork, carrying heavy loads, poor posture, bad bedding and curses. Some women recognized back pain as a symptom of reproductive tract infections (RTIs), but because these infections carry a stigma, these women did not seek immediate treatment.

In Kenya, women prioritized their health problems in terms of severity and whether their domestic chores were affected by them. In Sierra Leone one woman said: 'If the woman cannot get up to receive visitors in her home, then she is considered to be seriously ill'. Another woman said: 'Women must endure and be strong for as long as they are alive'. Women also consider whether the ailment from which they are suffering is socially accepted or 'hidden'.

What is a 'healthy woman'?

What is a healthy woman? 'Hard working, energetic, with smooth, shining skin'.

Local norms often define what a healthy woman is

'Hard-working, entertaining and good-looking'

A 'healthy woman' is defined by local norms. It is not surprising that in these patriarchal communities, men and women employ the same terms to describe a healthy woman. What is surprising, perhaps, is that women were more easily able to describe an unhealthy woman than a healthy one. This type of negative identification is a good example of the psychological constraints women in these communities must overcome when seeking health care. Interestingly,

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the terms used for health describe a woman's ability to perform the role that her society has constructed for her.

In Kenya a healthy woman was defined as 'a hard worker, early riser' and one who did not 'think too much' but was 'entertaining' – all attributes that enhance women's socially prescribed roles as caregivers, workers and wives. The converse, an unhealthy woman, is also measured against social norms. A respondent from Tunyai, in Kenya, reported that 'if a woman is constantly unhealthy, the community interprets it as a sign that she is not generous. Women are expected to serve others no matter the state of their health'.

In Nigeria a healthy woman was typically defined in terms of her physical attributes, temperament and capacity to work. Men were consistently found to use terms such as 'attractive body, fresh, shining, smooth skin, and without physical or mental deformities' to describe a healthy woman. Fulani and Maguzawa men insisted that she not be fat, as this is an indication of laziness. Both groups considered strong bodies necessary for performing the arduous work that women are customarily assigned. Furthermore, a woman should have a healthy appetite, sleep well, and be energetic and smart.

Nigerian women used terms such as laziness, leanness and dry skin to describe poor health. Kenyan women depicted an unhealthy woman as one who 'has frequent complaints, is unhappy, lacks appetite, and is weak, lazy', and whose skin and hair are pale or yellow. Women in Kenya said good health is sometimes 'taken for granted' until it is lost.

An unhealthy woman is a liability

In some cases, a chronically ill wife – for instance, one who suffers from sickle cell anaemia – will be sent back to her family or even divorced. In Nigeria, female respondents noted that cordial relations between a man and his wife depend on her good health: in a

polygamous household, a woman who is often sick is disadvantaged relative to the other wives. She may lose status to another wife who bears children more easily or has more stamina in the workplace. Most men value a woman only as long as she remains healthy and can attend to them. The moment a woman falls sick, she is seen as a liability and she is abandoned.

Consequently, women do all they can to stay healthy, and ignore symptoms of bad health as long as possible. One respondent noted, "No man likes today 'my back', tomorrow 'my head', and the next day 'my stomach'". Therefore, ailments such as headaches, fever, backache, menstrual pain, rashes and colds are often endured rather than mentioned. In Kenya, women cope by maximizing their healthy days, working hard to ensure they have surplus food in their stores for when they become incapacitated.

Disabled women suffer more

Disfigured or disabled women are seen as pariahs in their communities, and face constraints beyond the scope of their infirmities. In many cases they cannot find husbands, and often men take advantage of them sexually. In Sierra Leone feelings toward the disabled ranged from 'scorn, fear and shame to abuse and abandonment'. In Kenya disabled women are isolated by the society, and often find it difficult to participate in various developmental and social activities.

One man related the plight of his disfigured mother: 'Women who are disabled suffer a lot. My mother walks barefoot because she cannot wear shoes. When the earth is very hot she suffers even more. She cannot dance in traditional ceremonies yet she loves these dances very much. She cannot go to a place she wants because her pace is so slow. Thorns prick her, causing wounds to her bare foot. When she has all these problems, she sees herself as a misfit. She makes it up by being bad tempered and quarrelsome. This strains the relationships with members of the family'.

Where do women get health information?

In Kenya, women get information from a variety of sources, including clinic talks, posters in public places, women's groups and church meetings, the radio, friends and public meetings. The most popular means of receiving and exchanging information is through discussion in women's groups. In these settings, women feel they can ask questions without being threatened or embarrassed. Kenya has a strong women's movement that has been successful in challenging some of the cultural practices that lead to poor health, such as the taboo against the use of pit latrines. Health messages placed in the songs that women sing in these meetings are another popular source of information.

Women's groups are popular for exchanging information.

Radio can speak to women who are not free to go out.

In Nigeria, women mentioned most of the same sources of information as those in Kenya; however, the radio was emphasized as an important medium for receiving health information, particularly for women in Islamic communities who remain indoors during the day. These women were able to list several favourite health programmes on the radio by name. Television and radio also allow a family to receive information together, creating an opportunity for discussion among family members. One constraint some women mentioned was that they could not ask the radio questions.

For other Nigerian women, such as the nomadic Fulani, the radio is not very useful because the women spend most of their days selling their farm goods. For these women information is more likely to be received from hospitals, clinics and women's groups. Posters at these clinics are seen as an efficient and useful tool for delivering and reinforcing health information.

Praise singers, calabash beaters and dramatists draw large audiences and can be co-opted to deliver health information. In

addition, the women who are involved in the creation of these events tend to heed the message – and spread it.

Among sex workers, knowledge is communicated through radio, newspapers and staged drama. Sex workers also discuss their health concerns more openly than other women with local chemists, co-workers and the magajiya (head prostitute). Prostitutes and their clients remarked that there was not enough public information regarding STDs and their treatment.

Husbands are a source of information for women.

In many cases respondents mentioned their husbands as a source of health information. Men in Nigeria have more freedom to travel, as well as higher literacy rates, and thus more access to health information; however, this information is not always passed on to their wives. Men often referred to their wives as 'ignorant' on health matters. Furthermore, men seem unwilling to contradict traditional practices they know to be harmful to women, such as early marriage and circumcision.

Traditional birth attendants (TBAs) and healers also provide health information to women. Many of these informal health providers have some exposure to scientific methods as well as intimate knowledge of traditional cures. They are often the 'first line of defence' when a woman becomes ill and, in some cases, make referrals to modern services. TBAs are respected members of most communities, and are instrumental in giving prenatal and postnatal health advice to women. Elderly postmenopausal women, some of whom function as TBAs, could be a very valuable source for the provision of modern health information. In Nigeria, these women are free to travel, even to attend mosques, and are highly respected in the community. Their ability to take advantage of a variety of health delivery systems and to act as intermediaries for other, more restricted, women should not be overlooked.

Traditional birth attendants and healers are a source of information.

In Sierra Leone, health information is most commonly received from traditional healers and from modern health providers. Women have been 'exposed to very limited methods of information sharing and put a considerable reliance on the 'top-down approach' to learning health information'. However, one woman expressed some concern over learning too much about health: "My husband will think I stand over his head with knowledge".

Health workers can provide helpful information to women.

In areas of low female literacy rates, such as in Sierra Leone, posters and single-image photographs are ineffective when expected to function on their own because of difficulties with interpretation. Furthermore, radios are not commonly owned, particularly by women, and because radio information is 'one way', women do not regard it as a satisfactory tool for education.

What kinds of information do women listen to and why?

Most women in these studies preferred interactive methods where they could ask questions. Seminars at health clinics or small women's group meetings were considered effective means of providing health information, particularly among illiterate women, where posters and pamphlets are poorly understood; however, many respondents felt that one-way lectures from health officials were unsatisfying. They preferred open discussion, dialogue and storytelling. Muslim participants emphasized that women should receive health information only from female health workers.

One-way lectures from health officials are unsatisfying.

Women prefer interactive methods.

Clearly, some health information is reaching women. In every study the respondents recognized symptoms of malaria and understood, at least partially, its cause and methods of prevention and treatment. In Kenya and Nigeria most respondents had some grasp of biomedical explanations, and were growing increasingly frustrated with overly simple instructions. Some female respondents expressed concern about learning too much about STDs and other aspects of sexual health, as they felt that this knowledge could threaten their husbands and lead to allegations of promiscuity. Health information must be attuned to the varied conditions and cultural constraints under which women in developing countries live and seek health care.

Taking control: women's empowerment and health

The studies demonstrate that programmes which aim to empower women must take a multipronged approach. Literacy and adult education programmes are an important first step, but these, in isolation, will not improve the health of women.

The studies emphasized the importance of women's peer groups as a means of disseminating health information. This is a strategy that has been employed successfully in Zimbabwe, Puerto Rico and Kenya for AIDS prevention. In Sierra Leone, researchers highlighted the need for women's groups to expose the cultural taboos that are detrimental to women's health. Studies in Kenya have shown that groups of women can together effectively challenge some of these cultural constraints without undermining the social order. In Nigeria, young girls spoke positively about the role women's groups play in articulating the interests of women: 'Men cannot know or solve women's problems, and it is only when women come together that they can understand themselves'.

Women's groups, however, have their limitations. Among the nomadic peoples of Nigeria, whose movements are irregular, these groups are impractical. Most previous attempts to mobilize nomadic women have failed because the men fear that such activities will expose their women to city life and discourage them from remaining nomadic. All studies indicated that men approve of women's groups but are concerned about their potential to change women's traditional roles and practices.

The Nigerian study suggested that grass roots credit funds could be mobilized to pay transport fees and medical expenses for women. This would be helpful, as the high cost of medical treatment plays an important role in preventing women from seeking health care.

Credit funds can help improve women's health.

Many women respondents expressed the need for income-generating projects to allow them more autonomy.

Women's health improves when they earn and are free to use their own money.

Women's health improves when they have access to appropriate technology.

All the studies emphasized the need for gender sensitization of community members. Men's perspectives on women's health are often at odds with women's needs. Older men typically appreciate women for their procreative and social roles. Often men perceive women as contributing to their own ill health through such practices as abortion, adultery, promiscuity and laziness. These attitudes are deeply entrenched and may be difficult to change. Women often perpetuate their low status by socializing their own daughters to accept harmful cultural norms, such as female circumcision and early marriage.

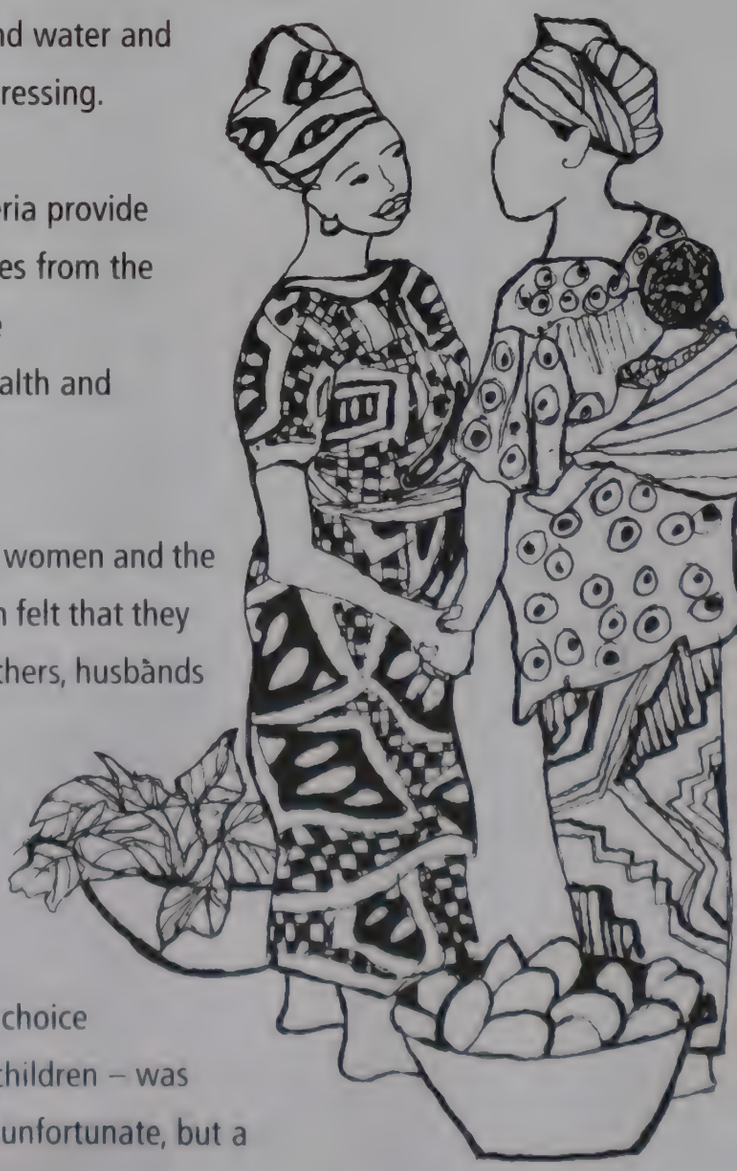
The need for female physicians in these communities is clear. Many women disregard or ignore obvious symptoms of poor health because they are ashamed to present themselves to male physicians. This reluctance to seek treatment frequently leads to aggravated conditions and late reporting of serious symptoms. Female health workers, generally from outside the area they treat, must also be sensitive to the varied cultural and social backgrounds of their patients.

There is a need for female physicians.

Introducing the Guide: a gender perspective

The process of developing the Healthy Women Counselling Guide has provided many important insights into what women in remote rural areas think about their health, the constraints under which they live, how men view women's health, where and from whom women prefer to receive information and what kinds of information they listen to.

For women in developing countries, as elsewhere, preservation of personal and family life, as well as caring for ill family members, is a primary responsibility. But the provision of health care is only one of a long list of responsibilities they assume. Other concerns, such as earning incomes, securing daily firewood and water and child care may be even more immediate and pressing.



The studies from Kenya, Sierra Leone and Nigeria provide useful insights into the context of women's lives from the perspective of gender power relations, and the constraints within which women cope with health and illness, both of themselves and their families.

All studies confirmed the subordinate status of women and the acceptance of women of this inferiority. Women felt that they should be submissive and respectful to their fathers, husbands and men in general. Their freedom to seek health care was also dependent on permission received from husbands and elders.

Women's status was dependent on their reproductive role. The concept of reproductive choice – at least in deciding whether or not to have children – was absent. An unmarried woman was considered unfortunate, but a

woman without children was viewed as unfulfilled and an aberration of nature. Childless women were objects of pity and sometimes derision.

Religion and 'culture' were widely used in defence of the subordination of women. In Nigeria and Sierra Leone, religion was used as a means to keep women in seclusion and to control their movements.

In all countries male attitudes towards women were ambiguous and often crudely dichotomized as 'good' or 'bad'. Men defined women's health in terms of their wives' capacity to meet their needs, both sexually and in the provision of home comforts. 'Good' women stayed home and concerned themselves with the well-being of husbands and children, always deferring to their husbands. 'Bad' women were prostitutes and the source of sexually transmitted diseases. Women were often blamed for their own illnesses, and stigmatized diseases, even those seen as 'men's' diseases, were believed to have been transmitted by women.

Women placed more importance on the health of sons and husbands than on their own health. This could be for at least two reasons: women have been socialized to defer to men and to value them highly, and the illness of male family members places an additional burden on women who are expected to care for them. Thus women are also better off if their sons and husbands are healthy. As women in Sierra Leone pointed out, 'When the men are sick, it becomes very difficult to run the homes'.

Women play a central role in perpetuating prevailing gender attitudes and thus strongly enforce the behaviour that discriminates against them. Women are responsible for much of the inculcation of behaviour patterns in the young. Girls are taught to defer to men and even boys from an early age. They learn to behave modestly and to undertake domestic work quietly and uncomplainingly. Boys have more freedom to play and generally receive more education. Men are considered heads of households and family decision makers even when they live elsewhere and return home only rarely.

Clearly, health information and counselling must be provided within the carefully circumscribed confines of women's lives, and efforts to reach them will succeed only if the possibilities and limitations of gender power relations within the community and family are kept firmly in mind. Health education must build on existing concepts of health that women already possess. Men and older women play pivotal roles in these societies because younger women depend on them for their livelihood and well-being. Their support, therefore, is key to the success of any intervention.

Next steps

Many questions concerning the ultimate form, entry points and dissemination of the Healthy Women Counselling Guide still remain unanswered, and specific materials have yet to be developed and tested. The three country teams that participated in the above studies are currently in the process of obtaining health materials from women themselves, including examples of posters, clinic talks and stories, based on particular health messages that the women themselves select. In addition, WHO is continuing to collect and evaluate examples of other health guides and approaches that have proven useful. At present, none of the illustrated health books or pamphlets adequately meets the challenge of providing information to illiterate women in a form that they can use without assistance from someone who can read and interpret the messages for them.

At the present time, community radio projects are springing up throughout the developing world, especially in Africa, and the future prospects of this medium for reaching women are bright. As we have seen, women in Nigeria and Kenya considered radio as an important medium for health education. Radio programmes have the advantage of being accessible to all family members, so that the information can be shared, referred to and discussed. Radio, therefore, is being actively explored as a means of reaching women.

Nonetheless, radio on its own has several disadvantages, including the problem of access in rural areas and the fact that radio is not interactive. These disadvantages can be overcome partially by providing the taped information that has been prepared for radio to care groups or women's listening groups in communities where

there is no radio. As we have seen, women liked to receive information in an interactive way, where questions could be asked and answered.

Radio could be used in combination with printed materials that women could use at home. Ideally, the printed materials should be available at a very low cost so that women could purchase them and keep them for their home use. These could be distributed by health centres, women's clubs or other outlets. A less costly alternative would be the provision of the printed materials on a loan basis from a central point such as the health post or village pharmacy. Such material would have to be produced in a durable, perhaps plasticized, form for lending purposes. WHO is currently pursuing the development of taped materials in conjunction with simple printed messages in the countries involved in the studies reported on here.

The most important of these is a manual, Health Workers for Change, that has been produced on the basis of methodology developed by the Women's Health Project in South Africa. The manual is designed to improve how health workers interact with their clients, especially women. With TDR support, it has been tested in four countries, modified, and is in the final stages of publication. Important linkages have also been built between researchers, non-governmental organizations and others working in the area of women's health, and practical approaches for integrating wider health and empowerment concerns with reproductive health services are being explored.

Even more important, perhaps, the Healthy Women Counselling Guide has become a philosophy that has broadened our understanding of women's health beyond reproductive roles to a truly holistic one that recognizes the wider gender framework that determines, to a large extent, women's control over their health and care that they receive.

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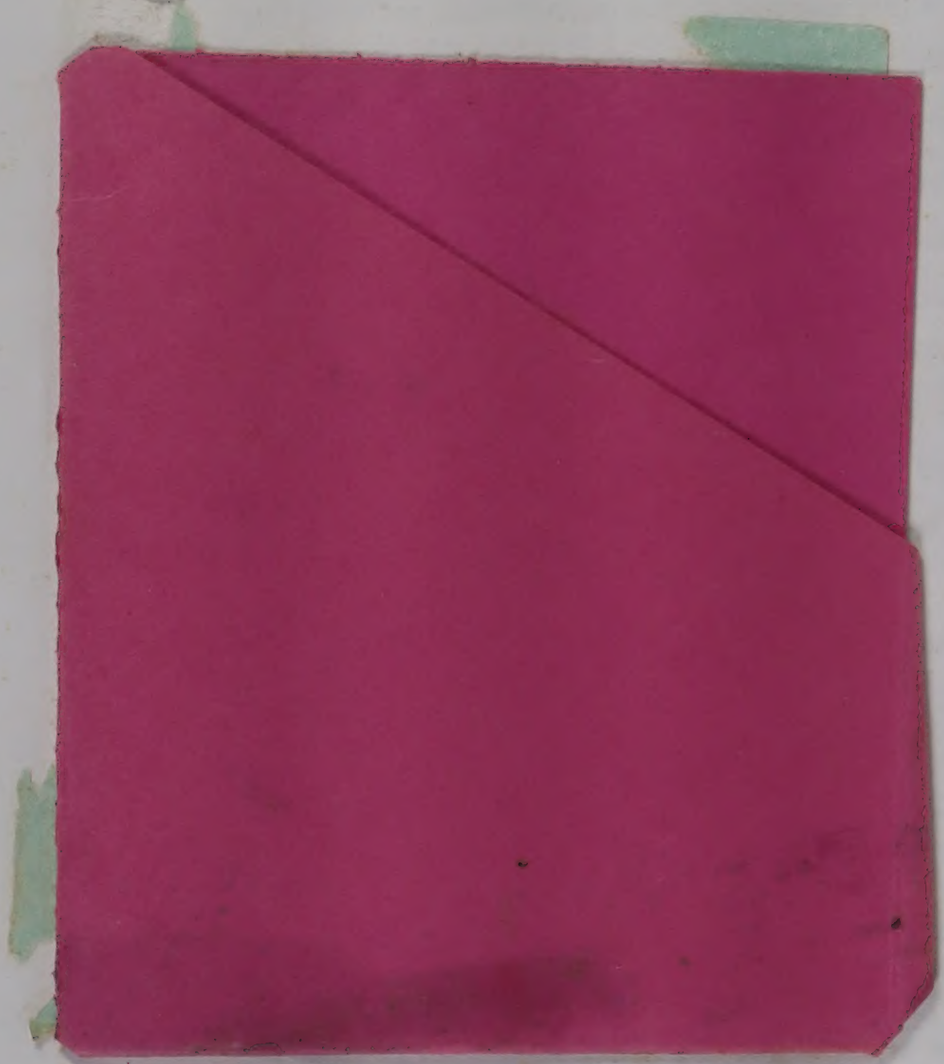

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